NUNM Health Centers Patient Registration
PLEASE WRITE LEGIBLY

Patient Name: ____ DOB: ____________________
Last Name First Name Middle Name

What is your preferred first name? (Nickname, Chosen name, etc) ______________________________

Address: ____

City: ______________________ State: __________ Zip Code: ______________

Home Phone: __________________ Work Phone: ______________________

Cell phone: ________________ Email address: ________________________

Preferred Contact Phone Number: ☐ Cell ☐ Home ☐ Work SSN: __________________

Is it ok if we email you with instructions to sign up for MyChart? ☐ Yes ☐ No

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The information you provide helps us to serve you and other members of the community and assists us to help you reach your health goals. Please answer all questions.

What is your birth sex? ☐ Male ☐ Female Other (specify) ____________
What gender do you identify as? ☐ Male ☐ Female Other (specify) ____________
What is your preferred pronoun? ☐ He ☐ She Other (specify) ____________

Interpreter needed? ☐ Yes ☐ No Primary Language: ____________________

Homeless Status? ☐ Not Homeless ☐ Homeless ☐ At Risk ☐ Transitional Housing ☐ Living in Shelter

Seasonal or Migrant Worker? ☐ Seasonal ☐ Migrant ☐ Neither

Ethnic Group (Select One): ☐ Hispanic ☐ Non-Hispanic Are you a US Veteran? ☐ Yes ☐ No Race

(Select all that apply): ☐ Asian ☐ Black ☐ White ☐ Alaskan Native ☐ Pacific Islander ☐ American Indian

Occupation: ______________________________________ Hours per Week: ________

Employer: _________________________ Address: __________________________

City: ____________________ State: ____________ Phone: __________________

Employment Status (Check one): ☐ Full Time ☐ Not Employed ☐ Part Time ☐ Retired ☐ Seasonal

☐ Self-Employed ☐ Student (Full Time) ☐ Student (Part Time) ☐ NUNM Student

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Primary Care Provider (PCP) Information (Please select one of the following):

☐ I wish to establish Primary Care with NUNM Health Centers.

☐ I see NUNM for ancillary/adjunctive care only.

My Primary Care Physician (PCP) is: ______________________________

At (Clinic Name): ____

☐ I do not have a Primary Care Physician and do not wish to establish Primary Care with NUNM at this time.

PATIENT REGISTRATION FORM CONTINUED

Emergency Contact Name: ____

Relationship: ______________________ Address: ______________________________

City: ____________________________ State: ______________ Zip: ______________

Home Phone: ________________________ Work Phone: ___________________________

Cell Phone: ________________________ Legal Guardian? □ Yes □ No

Guarantor (Person who is financially responsible for the account):

Name: _____________________________ Relationship to the patient: __________________

Address (if different from patient): _______________________________________

City: ____________________________ State:______________ Zip: ______________

Social Security Number: ________________ Gender: □ M □ F DOB: __________________

Guarantor Primary Language: __________________

The NUNM Health Centers Billing Department requires that ***all*** insurance coverage be pre-verified (7 business days) before we are able to bill for you. If this process has not been completed ahead of your appointment time, we will provide documentation of your visit to submit to your insurance company. You will be given any applicable discount for your office visit.

Please provide your insurance information below

Insurance Company:

Claims Address:

Subscriber Name (if other than patient): __________________________ DOB: ________________

Member ID #________________ Group # _____________ Subscriber ID #________________

****Please be prepared to present your insurance card at check-in at each visit****

****Although NUNM is not contracted with Medicare, it is our policy to collect all coverage information****

Do you have Medicare? □ Yes □ No If "yes", is it your primary insurance? □ Yes □ No

Medicare Plan (check all that apply): □ Part A □ Part B □ Advantage (Part C)

Subscriber ID #_________________ Effective Date (if known): __________________

I authorize the following individual(s) to arrange appointments at NUNM Health Centers on my behalf: (OPTIONAL)

Name: ___________________________ Name: ___________________________

DOB: ____________________________ DOB: ____________________________

Relationship to Patient: _________________ Relationship to Patient: _________________

I certify the above information is true and correct to the best of my knowledge.

_____________________________________ __________________________

Patient Signature **Date**